

# Re-Employed Retiree Membership Record and Employer Certification of Eligibility

State Form 50868 (R1/09-12-2002)

All Social Security Numbers are requested by this agency in accordance with the requirements of the Internal Revenue Code. Disclosure is mandatory and this form will not be processed without this information.

**INSTRUCTIONS:**

Please print or type in black ink.

Please forward the completed form to the Public Employees' Retirement Fund within five (5) days of the member's date of employment.

**You are required to submit a copy of the employee's Social Security Card with this form. If you do not submit a copy of their Social Security Card, this form will not be processed.**

## ENROLLMENT INFORMATION (To be completed by the Employer)

Social Security Number _ _ _ - _ _ - _ _		Date of Birth (mm/dd/yyyy)	
First Name	MI	Last Name	
Address			
City		State	Zip Code
Home Telephone Number		Other Telephone Number	
E-mail Address			
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		CURRENT MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	
<p><b>I certify that the individual named in this record is employed in an approved PERF-covered position. I understand that submission of this membership record creates a pension liability on the part of this employer and that employer and employee contributions must begin with the date of hire.</b></p> <p><b>I certify that I am the individual formally authorized to accept said liability for and on behalf of the governing body of this employer, and that the date of employment listed below is correct.</b></p>			
Date of Employment in this Position (mm/dd/yyyy)		Date Employer Contributions Will Begin (mm/dd/yyyy)	
Position or Title		Name of Employer	
Address			
City		State	Zip Code
Employer Phone Number		Employer Account Number	
Signature of Authorized Agent		Printed Name of Authorized Agent	

Member Name (Last, First Middle Initial)	Social Security Number _ _ _ - _ _ - _ _
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**BENEFICIARY INFORMATION (To be completed by the Employee)**  
Attach Additional Copies of this Page if Necessary

**Primary Beneficiary or Beneficiaries**

Beneficiary Name (Last, First, Middle Initial)		Social Security Number or Tax ID	
Date of Birth (mm/dd/yyyy)		Relationship to Member	
Street Address	City	State	Zip Code

Beneficiary Name (Last, First, Middle Initial)		Social Security Number or Tax ID	
Date of Birth (mm/dd/yyyy)		Relationship to Member	
Street Address	City	State	Zip Code

**Contingent Beneficiary or Beneficiaries**

Beneficiary Name (Last, First, Middle Initial)		Social Security Number or Tax ID	
Date of Birth (mm/dd/yyyy)		Relationship to Member	
Street Address	City	State	Zip Code

Beneficiary Name (Last, First, Middle Initial)		Social Security Number or Tax ID	
Date of Birth (mm/dd/yyyy)		Relationship to Member	
Street Address	City	State	Zip Code

In accordance with the provisions of Indiana Code § 5-10.2-3, I designate my beneficiary or beneficiaries as shown above. If the primary beneficiary or beneficiaries herein designated survive me, they shall receive the funds, if any, that are payable by the fund to a designated beneficiary. If the primary beneficiary or beneficiaries do not survive me then the secondary beneficiary or beneficiaries shall receive such funds. If none survive me, then the beneficiary shall be my estate. If no designation is made, any death benefit due would be payable to my estate. I reserve the right to change the primary or secondary beneficiaries at any time prior to retirement by filing a Change of Beneficiary form with the Board of Trustees of the Fund. Such a change must be received and accepted by the fund prior to my death for it to become effective.

I understand that this designation of beneficiary supersedes and replaces any prior designation of beneficiary that may have been made in the course of this or any prior employment in a PERF-covered position with any other employer.

Signature of Member	Printed Name
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Member Name (Last, First Middle Initial)	Social Security Number <div style="text-align: center;">             _ _ _ - _ - - _ _ _           </div>
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**PREVIOUS MEMBERSHIP INFORMATION (To be completed by Employee)**

Have you previously been employed in a position covered by the Indiana Public Employees' Retirement Fund?		YES		NO
If yes, are you receiving benefits from the Indiana Public Employees' Retirement Fund?		YES		NO
Have you previously been employed in a position covered by the Indiana State Teachers' Retirement Fund?		YES		NO
If yes, are you receiving benefits from the Indiana State Teachers' Retirement Fund?		YES		NO
Have you previously been employed in a position covered by an Indiana retirement fund other than PERF or TRF?		YES		NO

Member Certification	
<b>I certify that the information I have provided in this record is, to the best of my knowledge, accurate and complete.</b>	
Signature of Member	Date (mm/dd/yyyy)